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ORIGINAL ARTICLES

THE LOCAL ANESTHESIA METHOD.*

BY ROBERT EMMETT FARR, M. D.

MINNEAPOLIS, MINN.

The subject of local anesthesia presents so many phases, any one of which is of the utmost importance, that it is difficult for one to select in a short paper the particular ones which should be stressed at the present time. One is usually safe, however, in discussing principles, even at the risk of unnecessary reiteration and repetition. It is my desire tonight to consider the principles upon which the successful use of local anesthesia is based, outlining the ideals which should be our objective, provided the method is to be successfully employed, at the same time keeping in mind its practical application.

The Local Anesthesia Method. We prefer to consider the use of local anesthesia only in relation to other factors, such, for instance, as the manner of handling patients and the surgical technic employed, because of the fact that the successful use of local anesthesia depends to a greater extent upon the correlation of such adjuncts than upon the particular technic of using the anesthetic itself. We prefer, therefore, to use the term, "the local anesthesia method," a term which is comprehensive in that it includes many factors similar to the above mentioned examples.

Attention to the psychic care of a patient before, during and after operation, as well as the avoidance of unnecessary discomfort to the patient in regions outside of the operative field during operation, are prime essentials. This means constant vigilance and careful training of all who take part in the treatment of patients. The elimination of physical discomforts is especially important.

Demands of the Method. The use of local anesthesia demands special equipment, not only for the introduction of the solution, but as well for the carrying out of the special surgical technic

required. It also demands special training on the part of the surgeon, but fortunately much of this training may be acquired through a careful perusal of the current literature, occasional visits to the clinics of those who are more or less skilled in the use of the method, or by taking short, intensive courses, but mostly through its constant and repeated use in his own operating room. The position taken by some, that a long course of special training in the anatomical laboratory is necessary before one should attempt the use of local anesthesia, seems untenable. While such a course would undoubtedly be desirable, it is impracticable for the individual who is sufficiently well-trained in surgery, to spend any great amount of time in this kind of study, for, after all is said and done, the school of experience is the one in which results may be most easily and quickly accomplished. Fortunately, a surgeon may obtain much of this experience in his own operating room, without in any manner jeopardizing—indeed, usually with advantage to—his patient. For those desiring to perfect themselves in the use of local anesthesia, it is, therefore, only necessary, after a comparatively short course of training, to install the proper equipment and to begin operations more or less routinely with the use of local anesthesia, being prepared at any moment to supplement with general anesthesia, should the necessity arise. The compatibility of local and general anesthesia (ether or nitrous oxid) makes this method not only possible, but according to certain authorities, notably Crile, most desirable. The surgeon who is inexperienced in the use of local anesthesia, and who is desirous of perfecting himself therein, may accomplish a great deal in a comparatively short time by following this plan. He should realize in the beginning that his limitations must necessarily make it impossible for him to complete any considerable percentage of his operations without the aid of inhalation anesthesia. He must begin his operations with a firmly established resolution that he will not permit his patient to suffer pain. He must overcome the inclination which is inherent in most of us to conclude an operation begun under local anesthesia without resort to mixed anesthesia,

*Read by invitation before a called meeting of the State Society of Rhode Island, September 22, 1923.

regardless of the production of pain. He must decide to allow the patient to be the judge, and until he has had a comparatively large experience, the patient must be allowed to estimate the amount of suffering. As the surgeon's experience increases, he will find himself more competent to evaluate the merits of the patient's complaints, and gradually develop the ability to judge between real and assumed discomfort. He will, while developing this judgment, learn to meet the indications by supplementing with general anesthesia when necessary, or by so modifying the technic that pain and discomfort may be prevented. In this manner, by working along a constantly narrowing line or threshold, he will learn to anticipate procedures which may cause pain, and which at first cause him a certain amount of embarrassment, and not infrequently make it necessary to add inhalation anesthesia.

The Psycho-Anesthetist. One of the most important and useful adjuncts, and in fact, an absolute essential in the carrying out of this plan, is the presence of a skilled psycho-anesthetist, upon whose co-operation and assistance the surgeon may depend. The tactful psycho-anesthetist can do much toward enlisting the confidence and co-operation of the patient, and in addition, can be most helpful to the surgeon in conveying to him information regarding the effect of manipulations. The skilled psycho-anesthetist can, as a matter of fact, relieve the surgeon almost entirely of the responsibility of deciding when general anesthesia should be given. Should general anesthesia become necessary, this individual then becomes anesthetist, and the surgeon who is inexperienced in the use of local anesthesia will be surprised at the comparatively small amount of general anesthesia which is required in most of these cases to carry patients over critical periods.

Preliminary Narcotics. While it is perhaps desirable to precede local anesthesia operations by the administration of some hypnotic, and while there is no reason to question the efficacy of supplementing a light general anesthesia by the use of local anesthesia, we believe that until a surgeon has developed considerable experience in the use of local anesthesia, he will find it advantageous to begin operations with local anesthesia upon patients whose minds are not to any great extent obtunded. By so doing, the surgeon will find it

possible to evaluate the effect of his manipulations, and will thus more readily acquire an exact knowledge of the technic required in order to render a local anesthesia operation painless.

The surgeon, therefore, who wishes to develop himself in the use of local anesthesia, must give attention to the above mentioned factors, and so equip himself, that he may at least carry on on a small scale in the beginning. In so far as the carrying out of the operation is concerned, two important considerations present themselves. One relates to the actual induction of the anesthetic, the other to the surgical technic employed. We believe that the second factor is even more important than the first.

Induction of Anesthetic. The induction of the anesthetic should be made as simple as possible. Speed, accuracy and thoroughness are essential, but the avoidance of the production of pain and the thorough establishment of anesthesia, are the most important objectives. Speed and accuracy demand the most perfect working apparatus that can be obtained. Our personal preference is for the Pneumatic Injector, which furnishes us a solution under constant pressure, allowing us to introduce fluids into the tissues rapidly and accurately, and without distress to the patient. The employment of the pistol grip cut-off with its ball and socket adjustment allows one to introduce the needle in any direction, without the hand being placed in an awkward position, and the deepest cavities may be infiltrated without obstruction to the vision. With this instrument, accuracy is obtained by virtue of the constant flow of the solution, and consequently the liability of missing a small portion of the field is eliminated. In other words, one is not likely to "lose his place," as is the case when refilling or exchanging syringes.

Simplified Methods. Our preference is for the introduction of the solution into or near the field of operation or the line of incision. The avoidance of complicated methods, such as paravertebral and posterior splanchnic anesthesia for intraperitoneal work, is, it seems to us, most desirable. The time required, the irksomeness of preparing two fields, one for the introduction of the anesthetic and the other for the performance of the operation, the pain and discomfort incident to making the injection, the necessity for compelling the patient to change position between the admin-

istration of the anesthetic and the performance of the operation, all have a tendency to increase the handicap under which the method finds itself when compared with the use of general anesthesia by the average surgeon. If for any reason regional anesthesia is indicated, we prefer the infiltration block at the lateral margins of the anterior abdominal wall, as this may be made with the patient in position for operation. However, the indications for infiltration block have narrowed to the cases which present infection and to certain forms of hernia. In other regions of the body where the landmarks are certain, such as the intercostal, the cervical and brachial plexuses, or in the blocking of the branches of the trigeminus or sacral plexus, regional anesthesia is, of course, to be recommended. It is also most desirable to avoid piercing the sensitive skin repeatedly with even the finest needle. The so-called "subdermal"* method of anesthetizing the skin by which we devised many years ago the production of secondary wheals from beneath, which obviates entirely the necessity of causing the patient pain, is to be recommended. Anesthetizing the line of incision by the subdermal rather than intradermal method greatly simplifies and also accelerates the introduction of the solution. Every effort should be made to completely anesthetize the line of incision before the operation is begun. In intraperitoneal work, complete anesthesia of the abdominal wall only can be established before making the incision, unless posterior splanchnic anesthesia is employed. While making the incision, the reflex contraction of the muscles should be watched for carefully, and provided such contraction takes place, the anesthesia should be reinforced in the indicated area before such reinforcement is demanded by the patient's complaint. Careful attention to this detail will often allow the surgeon to anticipate such complaint. Every effort should be made to avoid pressure and manipulation which may transmit sensations beyond the anesthetized field. Thus retraction of the skin, fascia and muscular layers while incising, assumes considerable importance. The automatic wire spring retractors introduced in pairs effectually spread the walls of the incision gradually, thus exposing the successive layers.

In abdominal surgery, a definite routine is to be followed. Complete abolition of the reflexes of the abdominal muscles will effectually prevent any tendency toward extrusion of the viscera when the abdomen is finally opened, and allow one to enlist the force of gravity as a means of carrying movable viscera away from the operative field. By tilting the table in any desired plane, the desired region may be exposed. Here again, equipment becomes a most important factor. The operating table should, therefore, be of such construction that it may be tilted in any plane by means of the worm drive. It should be equipped with supports which will prevent the patient from slipping about. We use for this purpose adjustable metal plates, which are padded by segments of inner tubes stuffed with horsehair. The Trendelenburg position and its reverse, or the right or left lateral tilt, or even diagonal tilts, may be assumed with this form of equipment, without discomfort to the patient. The exposure obtainable when operating in the upper abdomen under the local anesthesia method, with the patient in the reverse Trendelenburg and without the spine being curved forward by the use of bags or pillows, must be seen to be appreciated. The descent of the liver and stomach from beneath the thoracic wall, aided by voluntary forced inspiration, greatly increases the facility with which operations in this region may be carried out. The principle is the same in the management of lesions in other regions of the abdomen.

Obtaining Adequate Exposure. It therefore follows that the most important objective in the performance of abdominal operations under local anesthesia is the securing of adequate *exposure*. The successful carrying out of the above technic, combined with elastic lateral retraction, and not infrequently, stealthy, vertical retraction of the abdominal wall will result in an adequate exposure, except in cases where marked distention is present. The performance of any intraperitoneal operation from this point on will depend entirely upon the induction of anesthesia of the abdominal sympathetics (splanchnic or pelvic) and the employment of surgical strategy.

Splanchnic Anesthesia. Anesthesia of the abdominal sympathetic nerves may be obtained in a variety of ways. We have found the anterior route the most satisfactory. In carrying out this

*Farr's "Practical Local Anesthesia." Published by Lea & Febiger.

procedure, we have modified the method first described by Braun, in which the fingers are introduced in order to define the region into which the fluid is to be injected. The discomfort which is usually occasioned by the introduction of the hand deeply within the abdominal cavity inspired efforts to establish anterior sympathetic anesthesia by a less painful method. The procedure which we have developed comprehends an exposure of the posterior parietal peritoneum when possible in appropriate regions, and the injection of the anesthetic thereunder, aided by direct vision. In cases in which visualization is possible, the induction of anesthesia is extremely simple, and it may be said that visualization may usually be obtained, provided the proper strategy has been employed up to the time that this stage of the procedure is reached. At this point, and until the intraperitoneal work is completed, it is absolutely essential that the interior of the abdominal cavity be properly illuminated, and artificial light only can be depended upon.

If adhesions are present, a good exposure permits their division, and after the introduction of an adequate amount of the solution retroperitoneally at the proper level, the indicated operation may be performed. As far as possible, traction should be avoided. This necessitates working upon the tissues and organs without roughly dislodging them. The operation should proceed in a stealthy, methodical, orderly manner. The patient's control of respiratory excursion, the absence of engorgement and expulsive efforts, gives one a silent field, which is often most ideal. The co-operation of the patient, which is enlisted through the agency of the psycho-anesthetist, is often of decided advantage. The liver and gall bladder or the stomach, duodenum and colon may at times be excluded by the patient at will. Suspected viscera may be visualized and manipulated in an effort to reproduce the patient's former symptoms, and by this means obscure diagnostic points may be elucidated. This attempt to reproduce pre-operative discomfort during operation, we have termed the "physiologic" test. The latter method has in our hands marked a decided advance in the clearing up of the diagnosis in certain abdominal conditions.

Routine success in this work can only be expected, provided some system similar to the above is adhered to rigidly. The following of such a plan will, without question, allow surgeons to perform a considerable percentage of major operations under local anesthesia with facility, dispatch, and often with great benefit to their patients.

In conclusion, may I once more express my thanks for your kindness in permitting me to deliver this message, and may I also express the hope that some of my hearers may experience in some degree the pleasure and satisfaction I have enjoyed in the application of the local anesthesia method.

FRACTURES OF THE FOREARM.*

BY DR. A. A. BARROWS.

PROVIDENCE, R. I.

In reporting three cases of fractured forearms treated by open reduction, I do not wish to be understood as an advocate of such a method in all cases of similarly broken forearms. These cases are presented merely as an illustration of one of the interesting problems that present themselves in the course of any surgical service at any hospital.

When, however, a case presents itself, showing fractures of both bones of the mid-forearm region, together with mal-position, over-riding, etc., there is at once presented a situation demanding very careful thought as to what the condition of that forearm is going to be after a lapse of six or more weeks.

It is, of course, quite possible in such cases, to so skillfully or fortunately reduce the fractures that an excellent result may be obtained after the necessary time for healing has elapsed, with no further trouble than the proper adjustments of splints and direction of the after care, or more probably, they can be successfully handled by the surgeon who is familiar and an adept in the use of traction combined with one of the splints of the Thomas type.

*Read before the Providence Medical Association, October 1, 1923.

When, however, such methods fail to give satisfactory reduction, and an X-ray picture that one can unquestionably satisfy himself is first class, the time has come to offer the patient the opportunity to have the situation improved by operative interference.

During my last service at the Rhode Island Hospital, there came in, as routine admissions, three patients, suffering from fractures of both the radius and ulna in forearm region. It has always been with more or less a feeling of dread that I have undertaken the responsibility of treating cases of this character.

The fear of a poor result, due to faulty position, non-union or adhesions, restricting full pronation and supination is always present when this type of fracture is seen, and whether it is the wisest course, from the viewpoint of both patient and surgeon, to treat them conservatively, with the dread of the aforementioned calamities in mind, or to cut down on them early and suture the ends of the displaced bones, assuming the risk of infection, is of course a question which each one must decide for himself. In each of these three cases, efforts were at first made to obtain satisfactory position by manual manipulations under ether, and later by traction, by means of adhesive plaster pull and a Thomas arm splint.

Two of these patients were working men, whose livelihood depended upon good forearms, and the third a young girl who was starting a musical education in the piano, hence, from the patient's viewpoint, much depended upon getting satisfactory results, and it was accordingly my best judgment to risk an open operation, in view of the fact that the early efforts had not been sufficiently successful.

Except in one case, where the patient was admitted badly shocked, after a severe, crushing injury to his chest, with many broken ribs, the decision to do an open reduction was made after a two weeks' trial of conservative methods. In the first case we waited a little longer, to allow the patient to recover from his shock.

It has been my experience that good results, if obtainable at all by traction and moulding, are always secured early and never late.

In each of these cases, it was found at operation that approximation and suture of the fragments of one bone (the radius as it happened) was suffi-

cient to give a result which would prove satisfactory, so that it was unnecessary to take the time and risk required to suture both bones.

These three cases were operated on in February, March and April of this year, and I have seen and examined all three during the past week, and find the results very satisfactory. All have no deformity and good union, full powers of pronation and supination, and no evidence of any nerve injury at time of operation. The results would appear to justify the method used in these few cases at least.

I would emphasize the fact that especial care and two days' time was spent in preparing all three cases for operation, and that the absence of any pre-existing septic focus determined before risking incision, and that during operation there was no handling of the tissues except with instruments, and that the radial nerve was in every case recognized and retracted away from the field of operation. All healed by first intention, and were able to leave the hospital within two weeks or less.

* * *

DR. HAMMOND: Mr. President, Dr. Barrows has given us a very interesting paper on a very difficult subject. I think all of you who have handled any number of cases of fracture of the forearm, especially both bones, will realize that it is often no simple proposition. It seems as though the forearm is entirely a different proposition than the lower leg, in which traction is often sufficient with moulding to press the bones into proper position. In my experience, the same methods do not hold with fractures of the forearm, and I have been unable to reduce such fractures by the use of splints of the Thomas type or other methods of traction. It is necessary to oftentimes angulate the bones and so spring them into position. After that they can usually be held with most any good type of splint. The proposition is more difficult the nearer you get to the forearm, where not only is union slow and sometimes difficult, but it is much more difficult to hold the bones into position in that location, and where both bones are broken at the same level in the middle of the forearm, it seems that the proposition is most difficult of all.

Oftentimes in children the X-ray looks very bad indeed, and yet if you can get one cortex to

the corresponding cortex of the other fragment, the bone will straighten out completely, and in a year's time, as I have seen demonstrated in many cases, it is difficult to know where the fracture was. In the case of children, I think the X-ray should be taken with a grain of salt, particularly if it shows great displacement, and at the same time the clinical picture is good; that is, if you feel clinically that if the child's forearm shows no displacement and the X-ray shows great displacement, it is better to go by your own judgment.

Sometimes these forearm cases must be operated upon as Dr. Barrows has demonstrated. I remember one case in which I worked nearly an hour, but was finally able to get the bones back in position. This is particularly the location where you find so many cases of non-union, and the fact that there are often soft splints at the time seems to be one reason why union does not take place more firmly.

I am glad Dr. Barrows brought out this very interesting phase of this very interesting subject.

* * *

DR. PECKHAM: I think this interesting paper ought to be discussed. When you get into fractures of both bones of the forearm, you get into deep water. I agree with Dr. Hammond in that I do not think traction in the forearm is the method of treatment for fractures of both bones. With splinting and plugging fractures into place, and angulation, you can reduce the vast majority of those fractures. Of course, it depends somewhat on the location. In some locations, it is almost impossible to get the two ends together. You get one or the other off, but by pressure and counter pressure and training, you can almost always do it.

In children, the bones will unite, and in a year's time after the bone heals, you cannot tell which one was broken. I learned that a great many years ago, and the first case I had was in a doctor's family. You get the darndest things in doctors' families. This little fellow broke his arm. I simply could not get those bones together. I was leaving town for a week, and suggested that while I was away the father take the child to a well known Boston man. When I came home, I expected to find everything over, but the father

brought the little boy in and said he went to Boston, and the doctor told him it should be splinted. "It is up to you to treat him." I did, and it has been reported before this society. Two or three other cases were also in doctors' families.

It is surprising what results you get. Within a year, I had a fracture in the middle of the forearm in both bones, and I could not get those bones anywhere near set, and I advised the open operation. The family physician of the man said there was some physical infirmity which he considered would be better without ether, and wanted me to do without it. From one point of view, the result was poor. There was delayed union, but they finally grew together, and the functional result was perfect. The bones were not in good apposition, but were more or less in alignment, and when union took place, the result was movement in every direction. Not being near a joint, there was no trouble with the joints. That was a delayed union.

There are cases of non-union. Instead of operation as before, I now use diathermy, giving a most satisfactory result in cases of non-union and delayed union, and it gives a perfectly good result in operative cases. I have also had cases, not in the forearm, but of bones of the leg, where there was non-union. I had one myself the other day in which there was no union. Diathermy gave a good solid bone union, which a splint was not going to give. One case was ten months after fracture. Of course, we know how bones look ten months after fracture. The ends of the bones are all capped over, and you would not expect anything to stir up the ossification there. I did not myself ten months after fracture. I advised that they allow me to operate again, and then use diathermy. I am glad that they did not. If I had, I myself would have thought that the operation did it, and not the diathermy. To get your results, you have got to give a good dose of diathermy. You have got to use it differently than in other cases.

I feel that operative work may be a necessity, but it should be seldom necessary. I think Dr. Barrows is to be congratulated from an operative point of view. There are some cases that demand it, but there should be very few, and I should not consider that in fracture of the forearm it is the thing to do.

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EDITORIALS

RADIO CONVALESCENCE.

When the first few days following a surgical operation have passed, the patient is usually fortunate enough to be considered an uninteresting case. The temperature chart shows normal lines, the discomfort attending a fresh wound has mostly disappeared, and the patient has little to do except lie quiet in bed and recover. This enforced rest in bed is very irksome to most patients and, with the exception of the effect of the anesthetic, is perhaps

the feature of a surgical operation most dreaded. Having nothing to do but lie in bed and get well, the patient spends his time worrying—about his wound, his stitches, his family, his finances, and what not. His bed is a hard bench, his room, a narrow prison. To a visitor, he seems to be plunged in the depths of despondency. Often his day is an unhappy vigil, still more unhappy if prolonged into the night.

Then enters a friend with a radio receiving set. He puts a box on the bedside table, connects a wire to the bed spring, another to the steam radiator, attaches a pair of ear phones, and the whole scene

is changed. The prison has become an auditorium, the pallet is an orchestra chair. Gone is despondency and weary vigil. A little grudgingly the patient lets you listen in. "Listen to the music. Isn't it wonderful?" Very likely the audience, with ear phones in place, falls asleep in the middle of the play and takes a long afternoon nap. It is just as well. There will be other plays.

The best radio equipment for the sick room is a simple set with a crystal detector or one audion tube, and a pair of ear phones rather than a loud speaker. A Gatch spring usually makes a satisfactory antenna or a wire may be stretched across the room near the ceiling. The ground wire is connected to the valve of the steam radiator or to a water pipe. This equipment is not in the way and does not interfere with the nurse, the surgeon, or the other patients in the hospital. Only those who have endured a long confinement in bed can entirely appreciate the importance of this development of radio as a therapeutic measure.

THE MORON AND HIS AUTOMOBILE.

Isn't it about time that the Legislature of Rhode Island did something to decrease the killing and maiming of the people by drivers of automobiles? That there are a certain number of hazards incident to the operation of any motor vehicle, by even the most careful and intelligent operator, admits of no argument; but why increase the natural risks of the business by allowing anyone who can answer a few questions on paper to go out on the highways and operate an automobile, when the most careless mother would not, if she knew it, allow him to push her baby in a carriage along the sidewalk?

What would be thought of an army training school which, without even the pretense of a practical test, yet gave its cadets a license to use firearms, simply because they could pass a paper examination? And what trade school, what professional school, would sponsor its pupils without ascertaining their actual abilities? And yet in this matter of licensing automobile drivers, the state at present demands no proof that the applicant is fit to drive anything whatever. Drawing a dia-

gram on paper and answering a few stereotyped questions is one thing; guiding an automobile through the intricacies of modern traffic is another and vastly different thing. You may be a moron and accomplish the former; you require a fair amount of intelligence to do the latter.

As things are now, what is to prevent a man with seriously defective eyes or ears from obtaining a license to run amuck? And how often do we all have to avoid the crazy gyrations of operators, who, by their actions, suggest the absence of any mental furnishings above the medulla? If these incompetents were a menace to themselves only, it would be bad enough; but to permit them to endanger the lives and limbs of others is as reprehensible in practice as in principle it is unjust. The exigencies of motor travel on modern highways demand intelligence and judgment: then why hand us over to the untender mercies of any mental defective who wants to drive an automobile?

We are properly alarmed by the increasing frequency of accidents caused by drunken drivers, but the truth of the matter is that probably not a few of these people were mental defectives before they touched alcohol, and should not be permitted to operate an automobile under any circumstances. Nowadays you need not so much brains as a pair of hands to acquire enough money to purchase an automobile, and so it behooves the state to protect us as well as it can from the morons among these newly-rich, who, in the not distant past, were accustomed to ride, for our safety and their own, on a trolley car, the motorman of which had received adequate instruction in his job. We ourselves know of a man, the unfortunate victim of major epilepsy, who was licensed to operate a motor car: that he was involved in no serious accident was due to the kindness of Fortune. And so, as we proceed with "Modern Progress," which teaches us that an automobile, like food, houses and clothes, is one of the necessities of life, we shall, no doubt, in sheer self-defense, be compelled to protect ourselves from the morons and worse who pre-empt the highways. We keep pistols and knives away from normal children: shall we then do nothing to stop these less than mental children from hurling their high-powered gasoline catapults upon our defenseless bodies?

THE PROTECTION OF MILK.

Milk is the one food that is used at all ages. It is the first food that the infant takes and often the reliance of old age when the teeth no longer perform their proper function. It is the one food that contains all the food elements in such proportion as to furnish a balanced ration yet, with all the advantages that this food possesses, the methods used to protect its purity are often archaic.

One disadvantage of milk is that it is a wonderful medium for the growth of organisms. These organisms often are not dangerous to health, but always there is the possibility of the pathogenic organisms infecting the milk and being carried to the consumer.

The two methods that are considered practicable in rendering the milk safe for human consumption are certification and pasteurization. There is no question that raw milk produced under ideal conditions is the best possible food, especially for the young. The ideal is very difficult to attain. Not only must the animal be free from disease and kept surgically clean and the plant, including stable and milk house, be free from dust and dirt, but also the men who handle the milk during the various processes must be free from disease and must be intelligent enough to appreciate the need for the cleanliness. To obtain the desired product with all these factors means the expenditure of money, and while certified milk will be necessary under certain conditions, the high cost will eliminate it as the food for the many.

Pasteurization of the milk supply of a community has been demonstrated as feasible and practicable, both as to cost and safety. The influence of pasteurized milk on infant mortality is undoubted, because the gastro-intestinal diseases, which are such a factor in increasing infant mortality, are practically eliminated by proper pasteurization. Scurvy may develop as the result of continued feeding of pasteurized milk, but this disease can be readily prevented and cannot be compared in its effect on the mortality with the gastro-intestinal diseases. The common objection against pasteurized milk is the selfish one of personal liberty. Certainly in this state, where the percentage of tuberculosis among cattle is so high, the inhabitants should be willing to be unselfish and realize that some protection to the milk supply is both necessary and desirable.

A CAMPAIGN OF SAFETY.

The JOURNAL observes with alarm the increasing toll of lives lost on the streets, no small proportion of which is of children. Whether or not we believe it to be in the province of the medical profession to revise traffic laws, certain it is that there is a very strong urge in medical and lay literature that the medical men interest themselves in the public welfare and take a more active part in civic and economic problems. Whether it is the streptococcus viridans or the deadly motor car it is a matter of life or death and perchance the medical press may help some in either case. Some time ago a strong article appeared in the lay press urging that a campaign to keep children off the streets and impress upon them the dangers of auto traffic be instituted. It was pointed out that a very little simple instruction in the schools and that perhaps a few traffic police on motor bicycles might instruct children at the school gates and on the road and by handing out broadsides in which the dangers of the streets were described in unmistakable language. It does not appear that any of these measures have been instituted. Immediately upon being dismissed from school the children spread themselves over the street, run back and forth in front of passing automobiles or solicit rides of the drivers. If there is an officer in attendance he does not in any way caution the children about keeping on the sidewalk but gives his entire time to the passing autos. We are informed that there is at present no instruction of this sort in the schools and if there is it is quite a failure as far as results are concerned. There is hardly a medical man who does not daily observe children with little carts, or playing in the streets, running after autos and even planning to run in front of them. The JOURNAL will wager a handsome pocket case against almost anything that some such plan as this would be the means of saving life and limb and also teach at the plastic age during the habit-forming period, a lesson of care that will be of immense help throughout future life.

PNEUMONIA AND OSTEOPATHY.

By MALFORD W. THEWLIS, M.D.

NEW YORK CITY.

The following discussion by J. C. Bierneman, in *The Journal of the American Osteopathic Association*

tion, October, 1923, brings to light the following summary of the osteopathic treatment of pneumonia.

"1. Management and osteopathic treatment are the same for lobar and broncho-pneumonia.

"2. Don't give any nourishment but allow plenty of water.

"3. Hot water bottle constantly to feet.

"4. Don't give whiskey or stimulants.

"5. Osteopathic treatment: Always a bony lesion in upper dorsal. One or more vertebrae or ribs are out of adjustment. It will loosen up and get motion in all spinal and rib joints the first visit. With patient on back his arms out at right angles, slip one hand under back above his arm. Place your finger tips on the angles of the ribs, lifting up body by pivoting on wrist. This gets motion and adjusts all upper dorsal vertebrae and ribs. Of course, I do this on both sides. Take hold of occiput in one hand and chin on the other and nod head backward and forward a few times. Place head in hollow of hands, fingers on the transverse processes and bend head and neck strongly from side to side. Do this with each neck joint. Make a fixed point of hyoid bone with your thumb and index finger and with other hand rotate head from side to side a few times. Do the same thing along the laryngeal cartilages. Place your hands on the shoulders and press down on clavicles to loosen them and take the arm out at right angles and pull up on clavicle.

"When I have a crisis in lobar pneumonia in which the patient is extremely prostrated with weak pulse or a broncho-pneumonia during the collapse stage with almost imperceptible pulse, inaudible second heart sound, cyanosis, extreme cold, clammy skin, inability to expectorate and very dull and listless, camp at the bedside for hours and treat often. Stick to your case and never give up. Don't let the nurse, relatives or medical doctor bluff you."

How delightfully simple this treatment is and what a sense of security the osteopath must have when he treats pneumonia! He does not have to worry about classifying the type of pneumococcus nor to make a diagnosis within the first thirty-six or forty-eight hours in order to give type I serum if it is a type I case. Hunton's investigations with the pneumococcus antibody solution showing that it probably contains protective bodies against

pneumococcus types I, II and III; that is polyvalent and possibly of value in type IV,—these are of no interest to the osteopath. How fortunate he is that he does not have to individualize his patient to ascertain if it is better to give the fresh air treatment or not; by constantly pounding on the patient he has tried to explode our theory that the great principle in the treatment of pneumonia is rest; infrequent examinations give this rest, but the osteopath believes in parking at the bedside and giving his patient exercise!

The osteopath is fortunate that he does not have to make sure that a good preparation of digitalis is secured and given early; he has no worries about obtaining good whiskey to give the patient as a food; nor does he have to bother about giving strychnine as a general stimulant. His diet is delightfully simple as far as being easy to prepare because he advocates no nourishment. There is one good recommendation he has made in giving enemas until the bowels are thoroughly cleaned, because it is essential to combat the toxemia of pneumonia; his recommendation to give plenty of fluids is also good. I should not care, however, to be on a low diet, nor should I care to take the osteopathic treatment for pneumonia.

The propaganda being spread by *The Journal of the American Osteopathic Association* is reaching between 40,000 and 50,000 laymen a month. The American Medical Association did well to start *Hygeia*, which is now reaching about 30,000 people, not as many, however, as the Osteopathic organization. Every encouragement should be given *Hygeia*.

SOCIETIES

THE PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. William B. Cutts, at 8:55 P. M., November 5th, 1923.

The minutes of the last meeting were read and approved.

The Standing Committee having approved the applications of Dr. Michael J. O'Connor, Dr. Alfred L. Potter, Dr. William N. Hughes, the

Secretary was instructed to cast one ballot for their election.

The Secretary reported that at the meeting of the Standing Committee held October 26, 1923, a copy of the *Boston Advertiser*, Providence Section, of October 21, 1923, was shown, and in it an advertisement of Dr. A. C. Maynard, of Providence, as a specialist on rectal diseases; and it was voted to recommend that the President appoint a committee to interview Dr. Maynard and ask him to give up his unethical methods, and that in case he does not do so to expel him from the association.

Drs. Skelton, Brown, Flanagan and Kelley spoke on this matter, and the President, Vice-President and Secretary were appointed such a committee.

The President reported the death of Dr. Louis J. Frink, was instructed to appoint a committee to prepare a memorial, and did appoint Drs. White, Skelton and Gray.

Dr. James M. Gallison, of Boston, read a paper on Intersusception in Adults. This paper was founded on a series of cases at the Massachusetts General Hospital and in the writer's private practice. He showed intersusception to be a terrible abdominal emergency, usually recognized late, and stressed the necessity of early diagnosis and prompt surgery. Tumor of the gut is the most frequent cause in adults, usually near the ileo-cecal valve. There is first colicky pain followed by intestinal obstruction and no definite remission of pain between attacks, as in infants. There is seldom or never blood or mucus in the stools. Treatment may be a plication of the mesentery or resection of the tumor, but in the great majority of the cases it is a gut resection, either primary or more often four to ten weeks after an enterostomy. He reported cases showing mistakes in diagnosis and treatment and also more favorable ones.

The paper was discussed by Drs. Matteson, Bugbee and Hussey.

Dr. C. O. Cooke read a paper on Complications following Surgical Operations, taking up phlebitis, parotitis, hemorrhage and pulmonary troubles. Drs. Hoye and Gardner discussed this paper.

A vote of thanks was extended Dr. Gallison.

Meeting adjourned at 11:05 P. M. Attendance,

90. Collation was served.

Respectfully submitted

PETER PINEO CHASE, *Secretary*

The Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Library, 106 Francis Street, Monday evening, January 7, 1924, at 8:45 o'clock, with the following program:

1. Reading of the records of the last meeting.
2. Report of the Secretary.
3. Report of the Treasurer.
4. Report of the Standing Committee.
5. Report of the Reading-Room Committee.
6. President's annual address.
7. Election of Officers and Committees for the ensuing year.
8. Appointment of Committees by the President.
9. Communications.
10. Reports of Committees.
11. Unfinished and new business.
12. Reading and discussion of papers.
13. Reports of cases.
14. Presentation of specimens.

By arrangement with the Retail Credit Men's Association of Providence, Mr. Charles E. Donilon, Credit Manager of the Boston Store, spoke upon the Collection of Accounts.

In accordance with Article I, Section 6, of the By-Laws, the Standing Committee presented the following nominations for Officers and Committees for the year 1924, who were duly elected:

For President—George W. VanBenschoten, M.D.
 For Vice-President—Albert H. Miller, M.D.
 For Secretary—Peter Pineo Chase, M.D.
 For Treasurer—Charles F. Deacon, M.D.

For Member of the Standing Committee for five years—William B. Cutts, M.D.

For Trustee of the Rhode Island Medical Library for one year—William F. Flanagan, M.D.

For Reading Room Committee—George S. Mathews, M.D., Herman C. Pitts, M.D., Elihu Wing, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society—J. B. Ferguson, M.D., H. E. Harris, M.D., B. H. Buxton, M.D., P. P. Chase, M.D., I. H. Noyes, M.D., P. T. Hill, M.D., W. P. Buffum, Jr., M.D., G. R. Barden, M.D., H. G. Partridge, M.D., A. H. Ruggles, M.D., A. M. Burgess, M.D., F. V. Hussey, M.D., W. F. Flanagan, M.D., F. N. Bigelow, M.D., M. B. Milan, M.D., H. B. Sanborn, M.D.

The Standing Committee approved the following applications for membership, and they were elected members of the association:

Charles L. Phillips, M.D., John A. Bolster, M.D.
 Collation followed.

DR. PETER PINEO CHASE, *Secretary*

KENT COUNTY MEDICAL SOCIETY.

At the annual meeting of the Kent County Medical Society held December 13, 1923, the following officers were elected for the ensuing year:

President, Gilbert Houston, Crompton; Vice President, F. G. Taggart, East Greenwich; Secretary, Charles S. Christie, Riverpoint; Treasurer, F. B. Smith, Washington; Censor for three years, Charles L. Phillips, East Greenwich; Censor for one year, John A. Mack, Crompton.

WASHINGTON COUNTY MEDICAL SOCIETY.

The Annual Meeting of the Washington County Medical Society was held at the Elm Tree Inn, Westerly, Thursday, January 10, 1924, with sixteen members present.

At this meeting one new member was admitted, which with three admitted during the year, makes our membership 29. Two have died during the year, Dr. Harold Metcalf, of Wickford, and Dr. John L. May, of Westerly.

Resolutions on the death of Dr. May were adopted at this meeting, being the same as those adopted April 12, on the death of Dr. Metcalf.

The Secretary was instructed to purchase a copy of the American Medical Association Directory for use of the Society.

A general discussion on "Compensation" laws and rulings occupied considerable time.

The report of the Treasurer showed the Society to be in a healthy condition financially.

Officers were elected for the ensuing year as follows: President—F. E. Burke, M.D., Wakefield. First Vice President—M. H. Scanlon, M.D., Westerly. Second Vice President—J. B. Warden, M.D., Ashaway. Secretary and Treasurer—W. A. Hillard, M.D., Westerly. Auditor—S. C. Webster, M.D., Westerly. Censor for three years—H. B. Potter, M.D., Wakefield. Delegate to Rhode Island Medical Society for two years—P. J. Manning, M.D., Wickford. Councilor to Rhode Island Medical Society for two years—F. I. Payne, M.D., Westerly. Alternate Councilor—M. H. Scanlon, M.D., Westerly.

Dr. Burke, the new President, reappointed Drs. Champlin, Scanlon and Duckworth as the Legislative Committee.

At one o'clock a recess was taken and dinner served.

Reassembling, Dr. Arthur T. Jones, of Providence, President of the Rhode Island Medical Society, addressed the meeting on "Cancer of the Breast."

The chair appointed Drs. Champlin, Savage and Scanlon a committee to introduce at the next meeting the subject of Medical Ethics and allied questions.

W. A. HILLARD, M.D.

Secretary

RHODE ISLAND OPHTHALMOLOGICAL AND
OTOLOGICAL SOCIETY.

One of the most interesting and best attended bi-monthly meetings of the R. I. O. & O. Society was held Thursday evening, Dec. 13, 1923, at the R. I. Medical Library, Dr. Bigelow presiding. The minutes of the previous meeting were read and approved.

1. Dr. Bigelow reported on the progress of the proposed bill concerning caustics and the labeling of the various articles containing caustics.

2. The name of Dr. Michael J. O'Connor was proposed for membership by Drs. Hawkins and Bigelow and referred to the Standing Committee for investigation.

3. The name of Francis B. Sargent was reported upon by the Standing Committee, and he was unanimously elected to membership in this society.

The treat of the evening was a very cleverly presented paper on Eighth nerve involvement, by Dr. Eugene A. Crockett, professor of Otology at Harvard Medical School. A wonderfully well presented paper showing an accurate knowledge of the subject on hand, and delivered in a most interesting way.

Dr. Crockett at the finish of his paper was extended a rising vote of thanks for his instructive thesis.

The paper was discussed by Drs. N. D. Harvey, Abbott, Sanborn and Porter.

Members present were: Drs. E. B. Harvey, N. D. Harvey, Best, Gilbert, Porter, McCusker, Ghazarian, Bigelow, Hawkins, Astle, Dowling,

Van Boschoten, Messinger, Abbott, Sargent and Walsh.

Several guests were entertained, including Drs. Fulton, Jones, Sanborn, Miller and O'Connor. Meeting adjourned at 9:45 P. M.

J. J. WALSH, *Secretary*

ANNOUNCEMENTS

THE CITATION IN THE AWARD OF THE SOFIE A. NORDHOFF-JUNG CANCER RESEARCH PRIZE.

"Dr. Johannes Fibiger, professor ordinarius in pathological anatomy at the University of Copenhagen, has demonstrated, following repeated experimentation, that parasites play an important role in the formation of certain types of tumors in the proventriculi of rats.

"Furthermore he has succeeded in effecting papillomata and undoubted carcinoma through the parasite nematode. Where others have failed after years of persistent researches, he first met with success in artificially inducing malignant tumors through external irritations and so thrown wide new avenues to future findings. Though the earlier results of Fibiger's work date back a number of years, he unremittently labored towards an interpretation of the significance of parasitic irritants in malignant tumor formation, likewise of mechanical and chemical irritants. Fibiger and his associates have contributed generously to the literature of cancer production through the feeding to rats of oats and the application of tar to their tissues. In this way they have confirmed the successful work of Stahr and Yamagiva.

"In a word, Fibiger's advances towards the solution of the problem of the causative irritants productive of cancer are at the same time most comprehensive and most remarkable.

"His name will ever appear inscribed on the first page of the History of Cancer Research."

The commission on the award consisted of Professors Borst, Doederlein, v. Romberg and Sauerbruch, all of the University of Munich.

THE AMERICAN CONGRESS OF INTERNAL MEDICINE.

The Eighth Annual Clinical Session of the American Congress on Internal Medicine will be held in the amphitheatres, wards and laboratories of the various institutions concerned with medical teaching, at St. Louis, Mo., beginning Monday, February 18, 1924.

Practitioners and laboratory workers interested in the progress of scientific, clinical and research medicine are invited to take advantage of the opportunities afforded by this session.

ELSWORTH S. SMITH, *President*.

St. Louis, Mo.

FRANK SMITHIES, *Secretary-General*,

1002 N. Dearborn Street, Chicago, Ill.

HOSPITALS

CITY HOSPITAL.

Dr. Julian M. Lyons and Dr. Robert S. Buol finished services of six months on January 1st, 1924, and began internship at the Rhode Island Hospital.

On January 1st, 1924, Dr. Earl F. Kelly and Dr. Joseph P. Nourie began service as house officers.

On December 19th, 1923, the monthly meeting of the Staff Association was held at the City Hospital. Dr. Elliott Washburn read a paper on, "Occupational Problems of the Tuberculous."

The following physicians have been appointed to the Visiting Staff of the Hospital for the year 1924: Pearl Williams, M.D., Michael J. Nestor, M.D., Carl D. Sawyer, M.D., Eric Stone, M.D., Bertram H. Buxton, M.D., Ira H. Noyes, M.D., Roy Blosser, M.D., James W. Leech, M.D., Henry Utter, M.D., Raymond Bugbee, M.D., Earl M. Bowen, M.D., George W. Waterman, M.D., John G. Walsh, M.D., Edward S. Cameron, M.D., William A. Mahoney, M.D., John T. Monahan, M.D., Maurice Adelman, M.D., William A. Mulvey, M.D., Guy A. Wells, M.D., Alex M. Burgess, M.D., Prescott T. Hill, M.D., Nat H. Gifford, M.D., J. Edwards Kerney, M.D., James A. McCann, M.D., Hilary J. Connor, M.D., Frederick J. Farnell, M.D., William Muncy, M.D., Harold G. Calder, M.D., Walter C. Robertson, D.M.D.,

Parker Mills, M.D., Alfred F. MacAlpine, M.D., Anthony Corvese, M.D., Alfred Potter, M.D., William P. Buffum, M.D., Edward A. McLaughlin, M.D., Reuben C. Bates, M.D., John A. Oslin, M.D., William W. Cummings, M.D., Henry S. Joyce, M.D., Elliott T. Washburn, M.D., William C. McLaughlin, M.D., Jeffrey J. Walsh, M.D., Henry I. Gallagher, M.D., F. Nolton Bigelow, M.D., Francis P. Sargent, M.D., Michael J. O'Connor, M.D., Antonio C. Ventrone, M.D.

joined the Providence Medical Association in 1917. He was prominently identified with Masonry, being a member of Oriental Commandery, Knights Templar, and the Oriental Chapter, R. A. M., of Bridgeton, Maine, the Providence Council and Palestine Temple, Mystic Shrine, of this city. He was also a member of Bridgeton Lodge, I. O. O. F., and the Independent Order of Foresters. Dr. Frink had the traits of a gentleman. Quiet, unassuming, he was always pleasant to greet.

WM. R. WHITE, M.D.

CREIGHTON W. SKELTON, M.D.

D. FRANK GRAY, M.D.

THE MEMORIAL HOSPITAL.

Meeting of the Memorial Hospital Staff held at the hospital January 8. About fifteen staff members were present and reports of the different services were read and approved. Discussion of cases by Dr. Jones and Dr. Oulton. All the officers of the previous year were re-elected, to include Dr. James L. Wheaton, President; Dr. John E. Donley, Vice-President; Dr. John F. Kenney, Secretary; Dr. Lambert Oulton, Treasurer.

Programme Committee consists of Dr. Elihu S. Wing and Dr. Eliot A. Shaw, Dr. Henry B. Moore. Meeting adjourned at 10:15 P. M.

JOHN F. KENNEY, M.D., *Secretary*

OBITUARY

Lewis J. Frink died October 31, 1923, in his 71st year, the cause of death being carcinoma of the liver and a cardio-renal condition associated with nephritis. Dr. Frink was the son of John and Hannah Frink and born at Gorham, Maine, September 17, 1853. He received his early education at the Kent Hill, Maine, preparatory school. After graduation he entered the office of the Maine Central railroad, where he remained for several years, after which he entered Dartmouth Medical College, from which he graduated in the class of 1888. He first located in Bartlett, N. H., where he practiced for fifteen years, and then went to Bridgeton, Maine, where he remained until fifteen years ago, when he came to Providence. Dr. Frink married Miss Susie Cummings, who died September 17th, 1918, on Dr. Frink's 65th birthday. There were no children. For the past five years he was physician to the Home for Aged Men and Aged Couples on Broad Street. He

RESOLUTIONS ON THE DEATH OF DOCTOR JOHN LAWRENCE MAY.

Adopted by the Washington County Medical Medical Society January 10, 1924.

Whereas, The Great and Supreme Ruler of the Universe has, in His Infinite Wisdom, removed from among us one of our most worthy fellows, Doctor John Lawrence May; and

Whereas, The long and intimate relations with him in the faithful discharge of his duties to this Society makes it eminently befitting that we record our appreciation of him, and therefore be it

Resolved, That the wisdom and ability which he exercised in the aid of our Society, by service, contributions, and wise counsel, will be held in grateful remembrance;

Resolved, That the removal of Doctor May from our midst leaves a vacancy and shadow that will be deeply realized by all the members of our Society, and will prove a serious loss to the State Society as well;

Resolved, That with deep sympathy with the bereaved relatives of the deceased, as well as the large constituency that he so long and faithfully served during his life as an honest, upright and faithful physician, we express our hope that even so great a loss to us all may be overruled for good by Him who doeth all things well;

Resolved, That a copy of these resolutions be spread upon the records of this Society, a copy printed in the RHODE ISLAND MEDICAL JOURNAL, and a copy forwarded to the bereaved family.

WILLIAM A. HILLARD, M.D., *Secretary*

MISCELLANEOUS

At a dinner recently given at the Hotel Commodore by the Rockefeller Foundation in honor of a group of health officers representing eighteen foreign governments, who for the past few months have been in the United States under the auspices of the Health Section of the League of Nations for the study and observation of various types of public health organization.

Dr. George E. Vincent, President of the Foundation, presided at the dinner. Dr. William H. Welch, Director of the Johns Hopkins University School of Hygiene and Public Health, in the absence of Dr. F. F. Russell, General Director of the Foundation's International Health Board, extended greetings to the foreign visitors on behalf of the public health workers of the United States. The other speakers were Mr. John D. Rockefeller, Jr., Chairman of the Board of Trustees of the Rockefeller Foundation; Dr. Hugh S. Cumming, Surgeon General of the United States Public Health Service; Dr. Linsly R. Williams, Managing Director of the National Tuberculosis Association; Dr. W. S. Rankin, State Health Officer, North Carolina; and Dr. Norman V. Lothian, of the Health Section of the League of Nations.

The visit of these health officials to the United States represents the third general interchange of public health personnel arranged by the Health Section of the League of Nations. The first took place in Belgium and Italy in 1922, and the second in England and Poland during February, March, and April, 1923.

In the present group are representatives delegated by their respective governments, among them many of the most eminent sanitarians in the world, from France, England, Italy, Russia, Poland, Spain, Holland, Belgium, Greece, Yugoslavia, Germany, Switzerland, Norway, Mexico, Salvador, Brazil, Chile, and Canada.

The system of international interchange of public health personnel was made possible by a contribution to the Health Section of the League of Nations from the International Health Board of the Rockefeller Foundation, amounting to \$60,080 a year, for a period of three years. The object of the plan is to bring the public health personnel of different countries into closer relationship with

each other, to effect a mutually profitable exchange of views on health subjects, to make comparative studies of health organization and legislation in different countries, and to promote international co-operation in establishing uniform standards for public health regulations.

GETTING THE BABY TO SLEEP.

Proper habits of sleep are almost as essential to the good health of an infant as is the right diet or sufficient exercise in the open air. Unless a baby gets plenty of sleep, he is certain to be nervous, irritable, and to grow more or less debilitated. During the first year, as a general rule, the more babies sleep the better. During the second year fourteen hours is the ideal amount and, in order to get this, a twelve-hour night must be supplemented by a nap of two hours during the daytime.

To encourage sleep the infant should be placed alone regularly at the same hour each afternoon and evening in a quiet, partially darkened room or in a protected situation in the open air. Regularity is of the utmost importance. A baby put to bed late one evening cannot be expected to go to sleep promptly the next. Nor should a baby be rocked, fussed over, or otherwise pampered at his bedtime hour. Such a practice, if indulged in, is certain to become habitual and to react to the detriment of the infant.

Not only is it important for a baby to sleep a sufficient number of hours out of the twenty-four, but he should sleep soundly while he is at it. To insure this he should be protected, so far as possible, from loud sounds, strong light and tactile sensations of every sort. Young mothers are liable to make the mistake of disturbing their babies by unnecessary attentions. The less done to a baby while he is asleep the better. Very often babies are kept awake by the mistaken ministrations of solicitous mothers, who fail to appreciate the fact that their babies' whimpering is in reality an appeal for sleep. A point, too, well worth emphasizing in this respect is that water given just before bedtime results in bed-wetting and consequently an unnecessary disturbance.

Altogether, a maxim well worth bearing in mind at bed time is: "Let well enough alone."—*Hygeia*.

FROM THE STATE OF NEW YORK

To those of our readers interested in the passing of definite medical laws in the State of Rhode Island, the following from the State of New York Department of Health by Dr. Matthias Nicoll, Jr., Commissioner, will be found interesting:

When questioned today regarding "fake doctors" practicing in upstate New York, Dr. Matthias Nicoll, Jr., State Commissioner of Health, stated that he knew of no instance similar to those which had aroused so much interest in Connecticut, where the doctors under investigation had all purchased their medical degrees from "diploma mills" or else had been licensed to practice in that state by buying their way through the state examinations in one way or another.

"Although in New York State the licensing of physicians is not by law a function of the State Department of Health, it is a subject in which the department is vitally interested. I am of the opinion," said Dr. Nicoll (who is also a member of the State Board of Medical Examiners), "that there are a goodly number of persons illegally practicing medicine in New York State. It is not necessary for one to prescribe medicine or to give drugs in order to practice medicine. The practice of medicine is defined by the medical practice act of this state as follows: 'A person practices medicine within the meaning of this article, except as hereinafter stated, who holds himself out as being able to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by any means or method, to diagnose, treat, operate, or prescribe for any human disease, pain, injury, deformity or physical condition.' Therefore, anyone who holds himself out as being able to make a diagnosis of physical ailments and to cure the same, unless he holds a license to practice medicine that has been issued by the Board of Regents of the University of the State of New York, is violating the law, and all such violators regardless of their method of violation should be prosecuted as such when sufficient evidence has been secured to convict them.

"Our medical practice act is ineffectual in that the county medical societies which are charged with collecting evidence and bringing the same to the attention of the district attorney of the county, to the end that he may prosecute the violator, are

not equipped for the task. The law should be so amended that the body charged with issuing licenses (the Board of Regents of the University of the State of New York) be empowered to collect evidence through properly appointed inspectors and when they have secured such evidence present it to the attorney general with the request that the violator be promptly prosecuted. If the case be a civil one the attorney general should conduct the prosecution. If it be a criminal case the district attorney of the county should prosecute it and have the assistance and co-operation of the attorney general's office.

"Recently a death certificate was filed with the Division of Vital Statistics of the State Health Department which emphasizes the grave danger of unlicensed medical practice. In the city of Schenectady a man died from lockjaw—probably the most horrible and agonizing death from which a human being can suffer. Investigation revealed the fact that some ten days previously this man, who lived in the outlying country, had been operated upon for cataract by an itinerant quack who guaranteed to cure the disease by means of a hypodermic injection of "radium" into the eye. It is highly improbable that any radium was used, and death was not due to any drug injected, but in all probability to the fact that the hypodermic needle or solution contained in it was contaminated with germs of lockjaw.

"This case is but one of many brought to the attention of the State Department of Health, and its outcome shows clearly the defect in our medical law. Before any action could be secured by the local county medical society against this itinerant quack he had gone out of the jurisdiction of the society and of the district attorney of that county. The difficulty is that no department has any record of the names of the duly licensed physicians who are legally practicing medicine in this State. In my opinion the medical practice act should be amended by requiring physicians to register annually with the Secretary of the State Board of Medical Examiners, list of such practitioners to be annually published by the State Education Department. Then we should at all times have an accurate record of every duly licensed physician in the State, and on twenty-four hours notice any person charged with practicing medicine illegally might be investigated, and if the charge found true promptly prosecuted."

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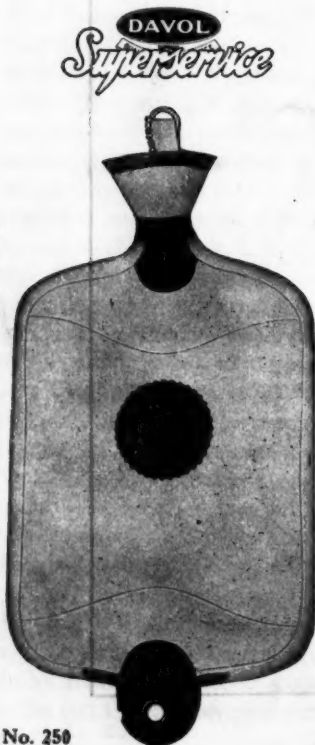
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